

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155209		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 06/04/2013	
NAME OF PROVIDER OR SUPPLIER WATERS OF CLIFTY FALLS THE				STREET ADDRESS, CITY, STATE, ZIP CODE 950 CROSS AVE MADISON, IN 47250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint IN00127389 completed on 4/26/13.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00129487.</p> <p>Complaint IN00127389 - corrected.</p> <p>Survey dates: June 3 & 4, 2013</p> <p>Facility number: 000116 Provider number: 155209 AIM number: 100266330</p> <p>Survey team: Brenda Buroker, RN-TC Diana Sidell, RN (6/4/13) Gordon Tyree, RN (6/4/13)</p> <p>Census bed type: SNF/NF: 105 Total: 105</p> <p>Census payor type: Medicare: 23 Medicaid: 74 Other: 8 Total: 105</p> <p>Sample: 3</p> <p>The Waters of Clifty Falls was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00127389.</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Quality review 6/07/13 by Suzanne Williams, RN	{F 000}			